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ABSTRACT

A Health Maintenance Organization (HMO) clinic on Chicago's Near North Side is currently offering physical and mental health care to Public Aid recipients. Psychological services are provided by a mental health co-ordinator (Ph.D. level) who supervises one or two counselors of M.A. status. The co-ordinator's other responsibilities include consultation with other staff members about patients, and close association with the head of Social Services, with whom many patients are shared. Counselors' responsibilities include testing and abortion counseling. Problems encountered and solutions formulated during the first year of the clinic's operation concern inappropriate referral to social services, patient absenteeism, and patient's attitudes of hostile dependency. Implications for counselor training are in the skill areas of interviewing, testing, and reporting of information. (Author/JLL)

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Counseling in a Medical Setting

As Part Of An HMO Team

by

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A Health Maintenance Organization operates under Federal funding with the provision of providing a total health care package to its patients, primarily individuals receiving some form of public welfare assistance. Medical, psychological, and dental services must be offered, with in-patient facilities available through co-ordination with a nearby hospital. In this way, Public Aid recipients are not forever filling out different forms to receive various treatments: their green Federal Aid card is merely kept at the clinic which is then responsible for all health concerns. This approach also centralizes information about each patient and eliminates the tendency to 'doctor-hop' on the part of patients while emphasizing 'the buck stops here' to the staff. The provision of psychological services at one such HMO clinic is the focus of the present paper.

The Near North Medical Clinic in Chicago services the northern and western fringes of the downtown area. Blacks, Chicanos, and Puerto Ricans make up the majority of its clientele. The Federal Housing Project in this neighborhood is the Cabrini-Green complex, now holding the dubious distinction of having the most serious crimes in the entire city committed within its district. The clinic is set up on a street corner in the heart of the commerical section, easily accessible by foot to most of the patients and by public transportation to the rest.

All patients, upon relinquishing their green cards and thus obtaining membership into the HMO, are initially screened by a nurse who takes their personal and medical history. At this juncture, referral is made to a particular physician. On the basis of the nurse's comments and/or the doctor's examination, referral may now be made to Psychological Services or to Social Services. Later, patients may again be referred from Social Services to Psychological Services, and vice versa.

Psychological Services at Near North consists of a Ph.D. level co-ordinator who supervises one or two M.A. level counselors. To increase client comfort, two black female counselors were initially hired, but only one remained, getting occasional help from a white male counselor. Interestingly, however, no problems of a racial nature ever arose between any of the clients and the white female co-ordinator. This only reinforces one basic contention of counseling: that one does not have to have been through an experience to be able to effectively empathize with it.

Once referred to Psychological Services, a patient has an intake session with the co-ordinator, either in person or by phone. Intakes serve three purposes: 1) finding out from the patient what the problem seems to be; 2) getting a commitment from the patient to enter counseling or testing; and 3) setting up an appointment for the client with either herself or one of the counselors. As most patients are assigned to a counselor, phone interviews were found very appropriate in not exposing the patient to too many faces, which might lead to further confusion.

In rare instances, the co-ordinator herself will handle the case, because of possible hospitalization of the patient, some sophisticated testing procedures required which the counselor could not handle, or when a referral is indicated to an outside agency or some other service of the clinic. Drug abuse and detoxification problems, for example, have been left up to outside agencies already at work in the community before the HMO clinic began. On the other hand, group treatment for obesity and child-rearing has been the province of Social Services, which already had on-going groups in these areas when Psychological Services were set up. In these instances, the aim has been to provide the most effective treatment for the patient with as little duplication of services as possible.

One interesting aspect of Near North's Psychological Services is its involvement with abortion requests. When a physician confirms a pregnancy and the

woman shows signs of not being able to cope with the situation, she is informed of available counseling, and that if she wants a legal abortion at a nearby women's clinic, the physician will sign the required form only after the woman has been to see a counselorat least once. This arrangement was set up to hopefully prevent any abortions had in desperation, the attitude of the staff at Near North being that abortion is serious enough to deserve serious consideration by the mother to attempt a well thought-out decision about both her future and that of her unborn child. In counseling, various alternatives to abortion are presented, the abortion procedure is discussed, and the emotional implications are investigated. Some patients report never having received this information before, and opt against an abortion. Some patients, of course, are extremely resistant to counseling, and are confronted with their feelings of guilt and anxiety. Most patients, however, remain with their abortion decision, but admit feeling better for the open discussion possible in the counseling setting.

One of the key words to success at Near North is co-ordination. For the Psychological Services, that is a major responsibility of the co-ordinator. This involves supervision of the counselors on a weekly basis, consultation with other staff members about patients, and close association with the head of Social Services, with whom many patients are shared. Education of the medical staff of the psychological problems of their patients is brought about by the psychological consultation forms placed in each patient's file after a counseling session. Physicians are then encouraged to consult with Psychological Services concerning treatment problems of the patient.

Problems

The problems encountered during the first year of the clinic's operation have been part of the over-all learning process for the staff. An initial problem, and one which still recurs, is with referrals. Inappropriate referral

to Social Services, after which the patient must be referred in turn to Psychological Services, is both time-consuming to the staff and cumbersome, in the least, to the patient. One solution has been for the physician doing the referral to state what treatment is indicated in his opinion, after which the directors of Social Services and Psychological Services decide which area can best serve the patient's needs.

Another area of concern has been with patient absenteeism. This problem is especially critical to Psychological Services staff, who are paid by hours of performance, not by hours on duty. An initial solution was to concentrate hours of attendance at the clinic from five days a week if necessary to two afternoons a week and Saturday mornings, with other times open for emergency. In this way, even if one patient did not show up for an appointment, other patients would have been scheduled for that day to make the trip worthwhile.

To combat the actual absenteeism problem, a number of actions were initiated. Before the counselor or co-ordinator left for the clinic, she would call each patient scheduled for that day: if the patient indicated not being able to come in, the appointment was re-scheduled and the staff's schedule shuffled to tighten the gap provided. Once at the clinic and the patient does not show up, the staff member again calls the patient, within half an hour of the appointment time. By calling early, the counselor may be able to re-schedule the appointment for that same afternoon; at the same time, the patient is aware of the staff's concern for his appearance at the counseling session, and that 'someone really cares.' Should a patient absent himself for two consecutive counseling sessions without a valid excuse (in the eyes of the counselor), outreach is undertaken by either a counselor or by Social Services staff, depending on the situation. Hopefully, patient resistance to counseling is thus ascertained.

While the two abovementioned problems can be roughly classified as procedural,

the third problem encountered often is more endemic in nature. During intake, the co-ordinator more often than not will hear the statements, "I need someone to tell me what to do" or "What can you do for me/my child?" These messages come through very clearly as needs for solutions and not resolutions, for responsibility to be on the counselor and not the patient. This situation is not unusual in the light of two factors: the clinic staff and the outside environment. At the clinic, the medical model of healer/patient is followed, so that is counseling, patients feel the same would also be true. In the outside environment, patients are reinforced for passivity with every welfare check they draw. An attitude of hostile dependency is thus fostered, which is extremely difficult to break down but which is crucial to do for the patient's future well-being. Confrontation and decision-making are the two most threatening elements of counseling to these individuals, who have been trained to look to their backgrounds and ethnicity for excuses instead of looking into themselves. The process of self-awareness is an arduous one for most patients at this clinic, but certainly well worth the effort.

Implications for Counselor Training

Now that a year has passed since the opening of the clinic, many ideas come to mind of skills either not acquired at all or not sufficiently stressed during academic training, which nonetheless were in great demand. Becoming comfortable in a variety of settings, even a medical examining room with a stethoscope at eye level, is very necessary if clients are in turn to feel comfortable during counseling. Interviewing, for intake and screening, should be practiced much more in the classroom until trainees begin to develop their own style of approaching clients, both in person and over the phone. Testing administration skills are in sore demand at a clinic, at which not only familiarity but actual ease in administration is required. Individual IQ tests and projectives are especially

needed in this type of setting, and can be extremely useful tools to a diagnostician trained in their art. Familiarity with diagnostic terminology is also essential, as is the writing of formal psychological reports. As to the counseling process itself, greater attention need be paid to decision-making models, counteraction to passivity and client manipulation, and assertiveness training, with emphasis placed on the role of the client in counseling and the signs to be aware of to change counseling strategies. The area of counseling in a medical setting is currently open, but without the above skills counselors will again be left out in the cold while clinical psychologists get all the positions.